

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

ADULT

This release expires 90 days from the date of signature or upon written request

Patient's Name: _____
Date of Birth: _____ Social Security Number: _____
Previous Name Under Which Records May Be Filed: _____
Patient's Current Address: _____
Patient's New Address if Moving: _____
Patient's Current Phone Number: _____ Patient's New Phone Number if Moving _____

I specifically authorize:
Name of Doctor/Facility: _____
Address: _____
To release all or part of my medical records as described on this form for the following reason _____

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI)

Please release my Medical Records to:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Please initial the appropriate box to indicate which records you wish to be released and be charged for:

- _____ Immunization records only.
- _____ Records generated in this office only (**not including** x-rays, fetal monitor strips, Electrocardiograms, old records, outside lab results) If no box is initialed, this option will be used
- _____ Records generated in this office only (**including** x-rays, fetal monitor strips, electrocardiograms, old records, outside lab results, which may incur an additional charge).
- _____ Other: _____
(specific dates of treatment or specific parts of the record).

Patient Signature _____ Date _____ (Patients 18 years and older must sign for themselves)
OR
Signature of Legal Representative _____ Date _____ Relationship to Patient _____

****PLEASE READ BELOW SECTION****

I understand that this separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that you release any information in my medical record pertaining to discussion, testing, diagnosis, or treatment regarding sexual activity, reproduction, birth control, sexual- or reproductive-related diseases, and addiction to or use of drugs.
Patient Signature _____ Date _____
OR
Signature of Legal Representative _____ Date _____ Relationship to Patient _____